Preschool Special Education Registration Requirements
Students Ages 3-5

New York State requires all Preschool aged students **suspected of** having a **disability** to register within their home District. In order to refer your child to Preschool Special Education, you must first register with the school district.

Please note that Wallkill CSD does not have a district preschool program.

To register you need to supply us with the following:

- Student Birth Certificate (Copy)
  Immunizations & Physical
- Two (2) Proofs of Residency (Must have Street Address dated within the last 30 days, Post Office Boxes will not be accepted)
- Custody Papers if applicable

Print and complete the forms attached below:

  Registration Form
- Emergency Procedure Form/Preschool
  Physical Form | Return Original Copy
- Home Language Survey
- Request for Time in a Regular Early Childhood Program
- Referral to CPSE with rationale

Return all documents to:

Wallkill Central School District
PO Box 310 | 1500 Route 208
Wallkill, NY 12589
Attn: CPSE

Please call (845) 895-7114 with any questions or concerns you may have.

If you are dropping off registration documents to the CPSE Department, the hours are 8:30-3:00 pm Monday through Friday.

**IS YOUR CHILD CURRENTLY IN EARLY INTERVENTIONS YES_____NO___COUNTY _____

Wallkill Central School District Student Registration Form 2026-2027

For Office Use Only

Date ___/___/_____ DOB ___/___/_____

Student's Name _____
Last First Middle

GENDER (check one) □ M □ F

SPECIAL EDUCATION SERVICES (check one) □ Yes □ No (If Yes, Please Provide IEP)

ETHNICITY (check one)

□Hispanic/Latino
□Not Hispanic/Latino

RACE (check one)
□American Indian or Alaskan Native
□Asian
□Native Hawaiian or Other Pacific Islander
□Black or African American
□White

Home Phone _____

Cell Phone _____

Email _____

FAMILY INFORMATION

Languages spoken at home _____

Student's language _____

The student's ability to speak English is (Check one) □ Fluent □ Good □ Fair □ Not at all

Student's place of birth _____ _____
City State

Custodial Papers (check one) □ Yes □ No (If Yes, Please Provide)

Does Student share households? □ Yes □ No [If Yes, Provide Information on Emergency Card)

Foster home placement (check one) □ Yes □ No

Agency Name/Address _____Telephone Number _____

****Is child living in any of the following situations (please check)**
□ living in a shelter □living with relatives or others due to lack of housing
□ living in a motel/hotel/campground/car/bus/train station/due to lack of adequate housing □ living in an alternative situation awaiting OCPS permanent foster care placement

2026 - 2027 WCSD Emergency Procedure Information

PRESCHOOL

For Office Use Only

Student ID# _____

***IS YOUR CHILD CURRENTLY IN EARLY INTERVENTION? YES_____NO_____COUNTY_____

Student Date of Birth: ____l____l

Student Name: _____ _____ _____

Last First Middle

Street Address _____ City _____ Zip _____

Mailing Address _____ City _____ Zip _____

Relationship and name of persons) with whom student resides: _____

Name of Primary Household Parent/Guardian _____Email_____

Home Telephone # _____Work Telephone # _____ Cell Telephone # _____

Name of Secondary Household Parent/Guardian _____Email_____

Home Telephone # _____Work Telephone # _____ Cell Telephone # _____

Siblings living in household:

Name _____DOB ___/___/___ School _____\ Name _____DOB ___/___/___ School _____

Name _____DOB ___/___/___ School _____\ Name _____DOB ___/___/___ School _____

Name _____DOB ___/___/___ School _____\ Name _____DOB ___/___/___ School _____

**Name, Address, Phone and Email of Parent NOT Residing with Student: **

**Name:_____Email_____

**Home Telephone # _____Work Telephone # _____ Cell Telephone #_____

**#2 Street Address: _____ City _____Zip _____

**#2 Mailing Address: _____ City _____Zip _____

Signature Primary Household Parent /Guardian _____ Date ____/____/_____

Signature Secondary Household Parent /Guardian _____ Date ____/____/_____

State Education Department / The University of the State of New York / I Albany, NY 12234
0ffl«e»f l°•t2

Lissette Colon-Collins, Assistant Commissioner
Office of Bilingual Education and World Languages

55 Hansen Place, Room 594
Brooklyn, NY 11217
Tel:(718) 722-2445/Fax(718) 722-2459

89 Washington Avenue Room 528EB
Albany, NY 12234
(518)474-8775 /Fax: (518)474-7948

Horne Language Questionnaire (HLQ)

Dear Parent or Guardian:
In order to provide your child with the best possible education, we need to determine how well he or she understands› speaks, leads and writes in English as we// as prior school and personal history. P/ease complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions in greatly appreciated. Thank you.

Please write clearly when completing this section.

STUDENT NAME:

First *Middle* *Last*

Date of Birth: *Month* *Day* *Year*

GENDER:
D Male
0 Female

Parent/Person in Parental relation info:

Last Name *First Name* *Relationship to student.*

Home Language Code

Language Background
(Please check all that apply.)

1. What Language(s) is(are) spoken In the student's home or residence	☐ English	☐ Other		
2. What was the first language your child learned'?	☐ English	☐ Other		
3. What is the Home Language of each parent/guardian?	☐ Mother		☐ Father	
	☐ Guardian(s)			
4. What language(s) does your child understand?	☐ English	☐ Other		
5. What language(s) does your child speak?	☐ English	☐ Other		☐ Does not speak
6. What languages(s) does your child write?	☐ English	☐ Other		0 Does not read
	☐ English	☐ Other		☐ Does not write

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

SCHOOL DISTRICT INFORMATION:	STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:
Wallkill CSD PO Box 310, Wallkill, NY *District Name (Number) & School* *Address*	

Home Language Questionnaire (HLQ)—Page Two

Educational History

8. Indicate the total number of years that your child has been enrolled in school _____

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write In English or any other language? If yes, please describe them..

*Yes** ☐ *No* ☐ *Not sure* ☐ *If yes, please explain: _____

How severe do you think these are? ☐ Minor ☐ Somewhat severe ☐ Very Severe

10a. Has your child ever been referred for a special education evaluation in the past? ☐ No ☐ Yes* **Please complete* 10b below

10b.. *If referred for an evaluation,* has your child ever received any special services in the past?
☐ No ☐ Yes – Type od services received: _____

Age at Which services (please check all that apply)
☐ Birth to 3 years(Early Int8rventlori) ☐ 3 to 5 years (Special education) ☐ 6 years or older (Special Education)

10c. does your child have an individualized Education Program (IEP)? ☐ No ☐ Yes

11. Is there anything else you think is important for the school to know about your child? (e.g., special talents, health concerns, etc..)

12. In what language(s) would you like to received information from the school? _____

_____ _____
Signature of Parent or of Person in Parental Relation Date

Relationship to student ☐ Mother ☐Falher ☐ Other:_____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ:

_____ _____

IF AN INTERPRETER IB PROVIDED, LIBT NAME, POSITION AND CREDENTIALS:

NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW:

_____ _____

ORAL INTERVIEW NECESSARY: ☐ NO ☐ YES

**DATE OF INDIVIDUAL INTERVIEW: _____ (MO DAY YR.)

Outcome of INDIVIDUAL INTERVIEW: ☐Administer NYSITELL ☐ ENGLISH PROFICIENT ☐ REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

_____

DATE OF NYSITELL ADMINISTRATION: _____ ACHIEVED ON ☐ Entering ☐ Emerging ☐ Transitioning ☐Expanding ☐Commanding

For students with disabilities, list accommodations, if any, administered in accordance with IEP pursuant to CSE recommendation:

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED IN ENTIRETY BY PRIVATE H£ALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or It, 1; 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special Education (CPSE).

STUDENT INFORMATION

Name:	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No	☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Yes, indicate type	☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No	☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other: _____

Seizures ☐ NO	☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Yes, indicate type	☐ Type: _____ Date of last **seizure:** _____

Diabetes ☐ NO ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached ☐ Yes, indicate type ☐Type 1 ☐ Type 2 ☐HbAlc results: _____ Date Drawn: _____

Risk Factors for Diabetes or Pre-Diabetes:

Consider *screening for T2DM If BMI'fi > 85'fi and has 2 or more rlsk factors.' Family Hx T2DM, Ethnicity, Sx Insulin Resistance,* Gestational Hx of Mother; *and/or pre-diabetes,*

BMI_____kg/m2 **Percentile (Weight Status Category):** ☐ <S" ☐5"-49" ☐ 50“-84" ☐85“-94" ☐ 9S"-98'^ ☐ 99"and>

Hyperlipidemia: ☐ No ☐ Yes Hypertension: ☐ No ☐ Yes

Physical Examination/Assessment

Height: Weight: BP: Pulse: Respirations:

TESTS	Positive	Negative	Date
PPO/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre- K & K			Date
☐Test Done ☐ Lead Elevated >10 pg/dL			

Other Pertinent Medical Concerns

One Functioning: ☐ Eye ☐ Kidney ☐ Testicle

☐ Concussion — Last Occurrence: _____

☐ Mental Health: _____

☐ Qther:

☐ System Review and Exam Entirely Normal

Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under *Abnormalities*

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

Diagnoses/Problems (list) ICD-10 Code

_____ _____

_____ _____

_____ _____

☐ Additional Information Attached

Name:			DOB:
SCREENINGS			
Vision	**Right**	**Left**	**Referral** / **Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No
Distance Acuity With Lenses	20/	20/	
Vision – Near Vision	20/	20/	
Vision – Color ☐ Pass ☐ Fail			
Hearing	Right dB	Left dB	Referral
Pure Tone Screening			@ Yes @ No
Scoliosis Required for Boys grades 9	Negative	**Positive**	**Referral**
And girls grades 5 & 7	☐	☐	☐ Yes ☐ No
Deviation Degree:		Trunk Rotation Angle:	
Recommendations:			

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

☐ **Full Activity** *without restrictions including* Physical Education and Athletics.

☐ **Restrictions/Adaptations** Use the Interscholastic Sports Categories (below) for Restrictions or modifications

- ☐ No Contact Sports — Includes: baseball, basketball, competitive cheerleading, field hockey, football, Ice hockey, lacrosse, soccer, softball, volleyball, and wrestling.
- ☐ No Non-Contact Sports — includes: archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field
- ☐ **Other Restrictions:**

☐ Developmental Stage for Athletic Placement Process ONLY
Grades 7 &8 to play at high school level OR Grades9-12 to play middle school level sports
Student Is at **Tanner** Stage: 0 1 0 II 0 III Q IV0 V

☐ Accommodations: Use additional space below to explain.

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device'	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety *Goggles*	☐ Other:

*Check with athletic governing body If prior approval/form completion required for use of device at athletic competitions.

Explain:

MEDICATIONS

☐ ***Order Form for Medication(s) Needed at School attached***

List medications taken at home:		

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS Received Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

Medical Provider Signature:	**Date:**
Provider Name: *(please print)*	Stamp:
Provider Address:	
Phone:	
Fax:	

Please Return This Form To Your Child's School When Entirely Completed.

WCSD

Wallkill Central 5choal District, 1500 Route 208, PO Box 310, Wallkill, NY *12589*
(845) 895-7114, Fax (845 j 895-8079

PRESCHOOL

DATE: _____

I, _____parent of _____

would like to refer my child for an evaluation to determine if he/she is eligible for preschool special education services. The reasons for this referral are as follows (please be specific):

_____

_____

_____

_____

_____

_____

_____
Parent Signature

Wallkill Central School District, 1500 Route 208, PO Box 310, Wallkill, NY 12589

WCSD

PRESCHOOL

Request for Time Enrolled in a Regular Early Childhood Program

Dear Parent,

As required by the New Yorlt State Education Department, all school districts must report the total time *parents* of preschool children have enrolled their child in any Regular Early Childhood Program. Examples of Regular Early Childhood Program could be private preschools, Head Start Centers, child care facilities or regular preschool classrooms open to pre-kindergarten population by the public school system.

To assist us in reporting this information to the New York State Education Department, please complete and return the enclosed form.

Thank you for your attention, and we appreciate your assistance in this matter. If you have any questions or concerns, please do not hesitate to call.

Sincerely,
Tara Rounds
Assistant Superintendent for Special Education and Intervention Services

WCSD

Wallkill Central 5choal District, 1500 Route 208, PO Box 310, Wallkill, NY 12589

Preschool

Request for Time Enrolled in a Regular Early Childhood Program

☐ My child does not attend a Regular Early Childhood Program

☐ My child does attend a Regular Early Childhood Program as indicated below:

The name oft1ieProgram(s) is/are: _____
And my child typically attends the program(s) for the amount of time of each day indicated below:

Monday	Tuesday	Wednesday	Thursday	Friday	Total Hours for the Week

_____
STUDENT'S NAME

_____
STUDENT'S DATE OF BIRTH

_____ _____
PARENT/GUARDIAN SIGNATURE DATE